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No. 97-

In the

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

The following question arises out of the State of Maryland's promulgation of a regulation designed to prevent insurers from circumventing State regulatory and consumer laws governing health insurance by offering a health insurance policy under the guise that it is a catastrophic or "stop-loss" policy:

Do the employee benefit pre-emption provisions of the Employee Retirement Income Security Act, 29 U.S.C. § 1144, bar the States from regulating stop-loss insurance policies that State-licensed insurance companies issue to employers to cover health-related claims of employees and their dependents?

PARTIES TO THE PROCEEDING

The parties to the proceeding below were American Medical Security, Incorporated; Client First Brokerage Services, Incorporated; Maran, Incorporated; Trio Metal Products Company, Incorporated; United Wisconsin Life Insurance Company (appellees below); and Dwight K. Bartlett, III, in his capacity as Insurance Commissioner for the State of Maryland (appellant below). Steven B. Larsen has since succeeded Mr. Bartlett as Maryland Insurance Commissioner and is accordingly substituted as a party under Sup. Ct. R. 35.3

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PETITION FOR A WRIT OF CERTIORARI

The Maryland Insurance Commissioner respectfully petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit.

OPINIONS BELOW

The April 11, 1997 opinion of the United States Court of Appeals for the Fourth Circuit is reported at 111 F.3d 358 and is reproduced in the Appendix ("App.") at 1a-15a. The court of appeals' May 6, 1997 order denying petitioner's request for rehearing and suggestion for rehearing in banc is unreported and is reproduced at App. 16a-18a. The February 23, 1996 opinion of the United

States District Court for the District of Maryland is reported at 915 F.Supp 740 and is reproduced at App. 19a-37a.

JURISDICTION

The court of appeals' opinion and judgment were entered on April 11, 1997. The order denying petitioner's timely filed petition for rehearing and suggestion for rehearing in banc was entered on May 6, 1997. This petition is filed within 90 days of that order pursuant to Sup.Ct.R. 13.3. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

This case involves the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1144(a), 1144(b)(2)(A), and 1144(b)(2)(B), and a regulation of the Maryland Insurance Commissioner, Code of Maryland Regulations, § 09.31.02. The text of these provisions are reproduced at App. 58a-62a.

STATEMENT OF THE CASE

This petition seeks review of a judgment of the United States Court of Appeals for the Fourth Circuit, which holds that ERISA pre-empts the State of Maryland from regulating stop-loss insurance policies that insurance companies sell to employers to cover health-related claims made by their employees and families.

A stop-loss insurance policy is a policy that an otherwise self-insured benefit plan purchases to insure an employer, which provides health insurance coverage to its employees, against catastrophic or unexpected losses. App. 40a. Stop-loss insurance policies contain "attachment points" above which the insurer reimburses the employer for claims paid. Payment of claims below the attachment

point is the responsibility of the employer and represents the level of self-insurance, or risk, that the employer retains. *Id.* Stop-loss policies typically have specific and aggregate attachment points. A policy with a specific attachment point provides that the employer is solely responsible for all claims filed on behalf of each employee up to a fixed dollar amount, and that the insurer's liability attaches for the employee's claims in excess of that attachment point. A policy with an aggregate attachment point provides that the insurer's liability attaches at a fixed percentage of expected claims for all employees.

There is no dispute that while the States may not regulate a self-funded ERISA plan's health-related benefits, ERISA nonetheless permits the States to regulate insurance policies that ERISA plans purchase to provide health benefits to employees. As the Maryland Insurance Commissioner stated, the law at issue in this case was prompted by the concern that stop-loss policies with very low attachment points constitute the equivalent of purchased health insurance and an effort by employers to evade Maryland's regulatory laws:

> The effect of having a low attachment point is that the insurance carrier issuing the "stop loss" coverage is, in reality, providing direct health insurance. The attachment point is merely a deductible. . . .When insurers undertake the subterfuge of categorizing an employer as self-insured, and thus exempt from the state's laws, yet provide an unapproved insurance product which acts as a replacement for direct insurance, consumers are denied the protections and benefits intended by the Maryland General Assembly.

App. 41a-42a.

Prior to promulgating the regulation that triggered this

litigation, the Maryland Insurance Commissioner had regulated stop-loss insurance and the appropriate attachment points for over twenty years. App. 40a. Minimum attachment points had been enforced as a matter of agency policy. Following the Maryland General Assembly's passage of significant health care reform in 1993, the Insurance Commissioner received complaints that stop-loss policies were being marketed with attachment points as low as $500 or $1,000. App. 41a. To respond to the complaints and the concern that insurance carriers were selling policies that did not comply with State law consumer protection provisions, the Commissioner proposed a regulation that established a specific minimum attachment point of $20,000 and an aggregate attachment point of 125% of expected claims. App. 38a. Policies with lower attachment points would be considered health insurance policies under State law and thus be subject to the provisions of the State insurance code. App. 40a; 55a.

As part of his regulatory review, the Maryland Insurance Commissioner in November of 1995 held a public hearing to receive testimony from affected citizens, including employers, insurers and the employee benefit industry, on the attachment points set forth in the proposed regulation. As set forth in an Order that the Commissioner subsequently issued in adopting this regulation, "[t]he vast majority of all witnesses and commentators have expressed the view that some attachment point is appropriate. Nearly everyone agrees that at 'low' attachment points, the policy in reality becomes a health insurance policy and not merely a catastrophic loss policy." App. 46a.

The Commissioner noted further that a representative of American Medical Security, a party in this case, testified that a "specific attachment point of $500 is 'abusive', that $2000 is 'absurd', that some regulation is necessary, and that a specific attachment point in the $5,000-10,000 range

is reasonable." App. 46a n.3. The Commissioner also concluded that the use of low attachment points "results in unfair competition in the insurance market" because it enables "companies selling unapproved stop loss policies" to "undercut" the efforts of insurers selling "approved products," who "spend a great deal of time and money to develop new products to comply with term and rate filing requirements and to remain competitive in light of the long list of Maryland mandated benefits." App. 41a.

Following the public hearings, the Commissioner adopted a modified stop-loss regulation that set a specific attachment point of $10,000. App. 56a-59a. The regulation does not apply to an employee benefit plan but rather explicitly applies to policies or contracts of insurance issued or renewed by insurance carriers and nonprofit health services plans. App. 56a-57a.

Maryland's regulation provides that a policy with an attachment point of at least $10,000 will be treated as a stop-loss health insurance policy that the Commissioner will approve. App. 58a. If the policy includes an attachment point that is below the regulatory minimum, however, the Commissioner will not approve it as a stop-loss policy but will instead consider it to be a health insurance policy, approvable only if it meets the State law requirements for health insurance. App. 57a-58a.[1] These requirements include, among other things, mandated benefits. App. 40a.

In late 1994, the Insurance Commissioner learned that one of the plaintiffs in this action, United Wisconsin Life Insurance Company, had been selling unapproved insurance policies to Maryland employers with specific attachment

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[1] No insurer may sell any insurance policy unless the policy is filed with and approved by the Commissioner. *See* Md. Ann. Code Art. 48A, § 375.

points as low as $2,500 and $3,000, well below the regulatory minimum. App. 23a. The Commissioner directed United Wisconsin, as a licensed insurer in the State of Maryland, to cease issuing stop-loss insurance policies that were not approved. J.A. 55-57.[2] The Commissioner issued a similar directive to another plaintiff, American Medical Security, which operated in conjunction with United Wisconsin, forbidding its sale of unapproved stop-loss insurance policies. J.A. 52-54. Both parties were informed that, under Maryland law, insurance contracts sold in the State must be filed with and approved by the Maryland Insurance Administration.

A licensed insurer's failure to obtain approval before selling an insurance contract could result in sanctions against the insurer in accordance with the Maryland Insurance Code. *See* Md. Ann. Code Art. 48A, § 375. No similar provision applies to employee benefit plans, however, and the Commissioner did not issue any order, request or demand of any kind to any employee benefit plan. No threat of sanctions or enforcement was made against any plan.

After being instructed to cease selling unapproved stop-loss policies, United Wisconsin, American Medical Security, and three small employers filed a complaint in the United States District Court for the District of Maryland seeking an injunction against the Commissioner's regulation, claiming that ERISA, 29 U.S.C. § 1144, pre-empts the Commissioner from regulating attachment points in stop-loss insurance policies. App. 20a. Jurisdiction was

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[2] References to "J.A." are to the Joint Appendix filed in this case in the court of appeals.

based on 28 U.S.C. § 1331 and ERISA, 29 U.S.C. § 1132(a)(3).

After the parties filed cross-motions for summary judgment, the district court entered judgment for the plaintiffs. The court first found that the regulation of attachment points "relates to" ERISA plans and, therefore, falls under ERISA's general pre-emption provision set forth in 29 U.S.C. § 1144(a). App. 27a. The court next determined that the regulation of attachment points "regulates insurance" within the meaning of 29 U.S.C. § 1144(b)(2)(A), since the "regulation 'directly controls the terms of insurance contracts' by mandating, *inter alia*, minimum attachment points in order for a policy to be considered stop loss insurance." App. 29a. While this type of regulation typically is not pre-empted under ERISA's insurance saving clause, the court nonetheless found that Maryland's stop-loss regulation "deems" ERISA plans to be insurers as set forth in 29 U.S.C. § 1144(b)(2)(B). App. 28a-33a. The district court accordingly held that the regulation of stop-loss attachment points is pre-empted under ERISA, and enjoined the Insurance Commissioner from regulating stop-loss insurance policies. *Id.*

The court of appeals affirmed. The court acknowledged that "plans that provide benefits in the form of insurance may be indirectly regulated through regulation of that insurance. . . ." App. 6a. The court then cited, *inter alia*, *Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649, 653 (4th Cir.1991), which explicitly rejected *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir.1987), in holding that ERISA pre-empts the application of State law to an employee benefit plan that purchases stop-loss insurance. Relying on *Thompson*, the court below stated that "plans that are self-funded or self-insured may not themselves be regulated as insurance companies even if the self-funded or self-insured plan

purchases stop-loss insurance to cover losses or benefits payments beyond a specified level." App. 6a-7a. The court thus affirmed the judgment of the district court, finding that "[e]ven though the regulatory language targets stop-loss insurance policies," the regulations violate ERISA because they "require self-funded plans to offer coverage consistent with state insurance law. . . ." App. 12a. The court of appeals subsequently denied Maryland's petition for rehearing and suggestion for rehearing in banc. App. 16a.

REASONS FOR GRANTING THE WRIT

This case presents the important question whether the States are barred from regulating a common form of insurance whose increasing popularity and misuse are having a substantial and adverse effect on millions of employees. Certiorari is warranted because the court of appeals resolved that question in a way that directly conflicts with this Court's holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), that the States *can* regulate insurance that is purchased by ERISA plans, and with decisions of the court of appeals for the Sixth Circuit upholding the States' right to regulate stop-loss insurance.

I. THIS CASE INVOLVES AN IMPORTANT QUESTION CALLING FOR THIS COURT'S INTERVENTION: WHETHER THE STATES CAN CONTINUE TO REGULATE A SIGNIFICANT AND EXPANDING PORTION OF THE INSURANCE INDUSTRY.

The use of stop-loss insurance as an ERISA plan funding device is growing and affects countless working citizens throughout the country. The United States General Accounting Office estimated in a recent report that approximately 114 million individuals representing 44 percent of the U.S. population are covered by ERISA health

plans, and that nearly 40 percent of these plans, covering about 44 million people, are funded at least in part by the employer. *See Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO-HEHS-95-167, July 1995, at 2-3. Moreover, as one commentator noted, "[t]he most recent data show that over 70% of otherwise self-funded plans are covered by some form of stop-loss insurance," and "that number is increasing." Paredes, T., *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. J. on Legis. 233, 235 (1997).

State insurance commissioners across the nation are currently regulating stop-loss insurance policies -- many by adopting minimum attachment points -- in response to concerns about the impact of their use.[3] Those concerns are

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[3] Maryland's regulation of stop-loss insurance policies is similar to regulatory action that a number of other States have implemented. *See* COLO. REV. STAT. § 10-16-119 (1995) (specific attachment point ("SAP") $10,000, aggregate attachment point ("AAP") 120%); CT Bulletin PC-7-90 (SAP $6,500); KS Bulletin 1993-12 and 1997-7 (SAP $10,000, AAP 125%); ME. REV. STAT. ANN., Tit. 24A, § 707(1)(c-1) (1994) and June 5, 1992 Guideline (SAP $10,000, AAP 120%); MINN. STAT. § 60A.235 (1995) (SAP) $10,000, AAP variable); MO. CODE REGS. tit. 20, § 400-2.150 (1995) (SAP $10,000, AAP 120%); 27 N.J. REG. 4320 (SAP $25,000, AAP 125%); OK Bulletin March 20, 1991 (SAP $7,500, AAP 120%); OR. REV. STAT. § 742.065 (1995) (SAP $10,000); TN Bulletin October 18, 1995 (SAP $10,000, AAP 120%); WASH. REV. CODE § 48.21.015 (1995) (SAP 5%/$100,000, AAP 120%). Several States also regulate stop-loss insurance by requiring forms to be filed and approved, and by imposing on insurance carriers that offer stop-loss insurance a number of requirements affecting their

(continued...)

that an expanding number of insurers are offering stop-loss insurance to enable employers to create the subterfuge that their health plans are self-funded. Once the self-funded label is attached to an ERISA plan, the plan is exempt from the States' laws regulating traditional health insurance, even though the employer hides behind the plan to transfer the bulk of its risk to an insurance carrier rather than hold the risk itself. The plan's "self-funding" is minimal, and the insurance package it purchases is a great deal more than a stop-loss package. Indeed, as the Maryland Insurance Commissioner found, "[t]he effect of having a low attachment point is that the insurance carrier issuing the 'stop loss' coverage is, in reality, providing direct health insurance" with the attachment point representing "merely a deductible" for the employer. App. 41a. The end result of this arrangement is an insurance package that "avoids all mandates and all consumer protections." *Id.*

In holding that Maryland has been pre-empted under ERISA from regulating stop-loss insurance policies that insurance companies sell to allegedly self-insured

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(...continued)
licensing status, the reserves they must keep and their guarantee fund responsibilities, and the mandated benefits they offer. *See* ALASKA STAT. § 21.12.050 (1997); FLA. STAT. ANN. § 627.6482; 215 ILL. COMP. STAT. 5/353 and 5/4 (1996); MICH. Bulletin 94-09; NH Insurance Regulation § 401.01(e)(3); N.C. GEN. STAT. § 68-50-130(5); and VA Administrative Letter 1980-7. In recognition of the national implications of this case, the National Association of Insurance Commissioners ("NAIC"), which is an association of the principal insurance regulators of the fifty States, the District of Columbia, and the four United States territories, filed an amicus brief in support of the Maryland Insurance Commissioner in the court of appeals below.

employers, the court of appeals has fashioned a rule that strips the States of any ability to enforce legitimate and important health insurance requirements, and precludes the States from prohibiting even sham arrangements in the health insurance industry. Congress did not intend ERISA to prevent the States from addressing a matter of such historical local concern, nor did it mean to allow an employer to seek shelter under federal law from general health care regulation when, as in the situation addressed by the laws of Maryland and many other States, the employer uses stop-loss insurance to cover the health-related claims of its employees and their dependents.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS.

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), this Court held that ERISA does not pre-empt the States' regulation of insurance policies providing health coverage that insurance companies sell to ERISA plans or employers. The court of appeals' decision prohibiting Maryland's regulation of stop-loss insurance directly conflicts with *Metropolitan Life* because stop-loss insurance is insurance that a carrier sells to employers to cover employees' health claims. The court of appeals compounded its error by disregarding this Court's repeated admonishment that proponents of ERISA pre-emption "bear the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S.Ct. 1747, 1752 (1997) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S.Ct. 1671, 1676 (1995)).

The law at issue in *Metropolitan Life* required the inclusion of minimum mental health-care benefits in insurance policies that ERISA employee benefit plans

purchased. The Court initially found that Massachusetts's law "relate[s] to" a benefit plan and so fell within the reach of the pre-emption provision set forth in 29 U.S.C. § 1144(a), which provides that, "[e]xcept as provided in subsection (b) of this section," the ERISA statute "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." The Court nevertheless held that the State's law was exempted from § 1144(a) by the "saving clause" set forth in § 1144(b)(2)(A), which preserves any State law that "regulates insurance, banking, or securities." Stating that the Court "must presume that Congress did not intend to pre-empt areas of traditional state regulation," 471 U.S. at 740, the Court applied the plain language of the saving clause and held that Massachusetts's law was not pre-empted because it "regulates the terms of insurance contracts, and so seems saved from pre-emption by the saving clause as a law 'which regulates insurance.'" *Id.*

Maryland's law similarly falls within the scope of the saving clause because, as the court of appeals in this case recognized, Maryland's "regulations are carefully drafted to focus directly on insurance companies issuing stop-loss insurance and not on the employee benefit plans themselves." App. 11a. The court found, however, that because the regulations' "purpose and effect are directed at self-funded employee benefit plans that attempt to provide fewer health benefits to Maryland residents than state law mandates for health insurance policies," *id.*, "Maryland's law violates the ERISA provision that no ERISA plan 'shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.'" App. 12a (quoting 29 U.S.C. § 1144(b)(2)(B)). The court of appeals fundamentally misinterpreted ERISA in a way that cannot be reconciled with *Metropolitan Life*.

The "deemer clause" that the court relied upon in finding that Maryland's law is pre-empted actually reinforces the opposite conclusion. That clause provides that an employee benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." As this Court stated in *Metropolitan Life*, "[b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." 471 U.S. at 741. The court of appeals thus misapplied the deemer clause, because that clause "makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts. . . ." *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990).

As a result of this error, the lower court ignored the crucial distinction between the direct application of a State law to an insurer, which ERISA permits, and the direct application of the same law to an employee benefit plan, which federal law prohibits. *See Metropolitan Life*, 471 U.S. at 735 n.14 and 746-47; *FMC Corp.*, 498 U.S. at 62. ERISA does not pre-empt a State law that regulates insurance contracts merely because, as the court of appeals found to be the situation here, the State law has an indirect effect on employee benefit plans when it uses "insurance policies as a vehicle to impose the requirements of . . . health insurance law" on those plans. App. 12a. On the contrary, this Court in *Metropolitan Life* made clear that an employee benefit plan that purchases insurance to cover the health-related claims of its employees is *not* exempt from the States' historic right to regulate insurance contracts,

even when a State's law "bears indirectly but substantially on all insured benefit plans" by "requir[ing] them to purchase . . . benefits specified in the statute when they purchase a certain kind of common insurance policy." 471 U.S. at 740. *See also New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S.Ct. at 1680 ("[L]aws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans."). The court of appeals was wrong in finding otherwise, therefore, because "employee benefit plans that are insured are subject to indirect state insurance regulation." *FMC Corp. v. Holliday*, 498 U.S. at 61.

The court of appeals' misapplication of these principles is attributable to its mistaken belief that an ERISA plan affected by Maryland's law is "self-funded" or "self-insured" -- and thus exempt from regulation under the deemer clause -- even when the "plan purchases stop-loss insurance to cover losses or benefits payments beyond a specified level." App. 7a. As this Court has recognized, however, "nothing in [the saving clause], or in the 'deemer clause' which modifies it, purports to distinguish between traditional and innovative insurance laws." *Metropolitan Life*, 471 U.S. at 741. Maryland has the right to regulate stop-loss insurance because "[a]n insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation." *FMC v. Holliday*, 498 U.S. at 61. In these circumstances, "[t]he ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer." *Id.*

It is undisputed in this case that, as the court of appeals repeatedly found, Maryland's law on its face applies only

to insurers. *See, e.g.*, App. 10a-11a ("The regulations, by their own terms, seek to impose requirements only on insurance companies and their stop-loss insurance policies."). It is also undisputed that the Maryland Insurance Commissioner has taken no action to enforce the State's law against anyone other than the insurer, and that no employer or employee benefit plan has been required or even asked to do anything with respect to Maryland's law. The Commissioner is simply not regulating ERISA plans in any fashion, but is instead regulating an insurance company in the sale of insurance. ERISA does not pre-empt such traditional State regulatory activity; rather, the explicit language of "the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans." *FMC v. Holliday*, 498 U.S. at 64.

In incorrectly applying ERISA, the court of appeals has erected a rule that deprives the States of any authority to regulate an increasingly used insurance device that more and more States have sought to regulate because of its high potential for abuse. *See also Employer-Based Health Plans: Issues, Trends, and Challenges Posed by Erisa*, United States General Accounting Office, GAO/HEHS-95-167, at 16 (to address "new stop-loss insurance products that . . . allow small firms to self-fund, avoiding state regulation, while only bearing a small portion of the risk. . ., the National Association of Insurance Commissioners (NAIC) is developing a model act that would define minimum stop-loss coverage levels, preventing the sale of products that are merely a subterfuge for traditional health insurance."). State regulatory bodies must have the ability, however, to "look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan

participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants." *Brown v. Granatelli*, 897 F.2d 1351, 1355 (5th Cir.), *cert. denied*, 498 U.S. 848 (1990).

Applying that scrutiny to stop-loss policies issued in Maryland, the State's Insurance Commissioner found that a stop-loss insurance policy with a low attachment point is the equivalent of a health insurance policy with a deductible and, therefore, must provide the protections and benefits mandated by Maryland law. App. 41a. Congress did not intend to prohibit the States from exercising their right to regulate insurance in circumstances such as these and to determine the substantive terms of insurance contracts that licensed insurers sell.

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS.

Review is also warranted because the court of appeals' decision conflicts with decisions of other federal appellate courts. In *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir.1985), *cert. denied*, 474 U.S. 1059 (1986), the court of appeals held that ERISA does not pre-empt the application of a State mandated-benefit statute to stop-loss policies that insurance companies sold to otherwise self-funded ERISA plans. Finding this Court's decision in *Metropolitan Life* to be controlling, the court of appeals stated that "[t]he stop-loss nature of the plans does not alter our conclusion," 767 F.2d at 312, and concluded that "[a]s long as the plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified by [Michigan law]." *Id.* at 313.

In *Northern Group Services, Inc. v. Auto Owners*

Insurance Company, 833 F.2d 85 (6th Cir.1987), *cert. denied*, 486 U.S. 1017 (1988), the court of appeals reaffirmed this holding in finding that ERISA did not pre-empt the application of a Michigan coordination-of-benefit statute to an ERISA plan that was covered by stop-loss insurance. Stating that "direct regulation of the content of insurance policies that an ERISA plan purchases is not barred by the deemer clause," 833 F.2d at 90, the court rejected the plan administrator's argument that the plan was "self-insured" and thus exempt from Michigan's law. Rather, the court held "[t]hat the Plan pays a deductible does not alter the fact that benefits payable above specified levels, either on an individual beneficiary or in the aggregate, are nonetheless insured." *Id.* at 91. Accordingly, the court held that State law as applied to the stop-loss insurer was not pre-empted.[4]

Neither of these decisions can be reconciled with the decision of the court of appeals below. The Michigan law at issue in *Michigan United Food* was much more sweeping in its scope than the law that the court of appeals invalidated in this case: Maryland's law imposes mandated benefits only on those stop-loss policies that have been determined to be, in reality, health insurance policies, while Michigan's law imposed the mandated-benefit requirement

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[4] The court also held that ERISA did not pre-empt the application of Michigan's law to three plans that were "totally self-insured." 833 F.2d at 91. This portion of the court's decision was later overruled in *Lincoln Mutual Casualty Company v. Lectron*, 970 F.2d 206, 210 n.3 (6th Cir.1992), as "no longer viable" in light of this Court's intervening decision in *FMC v. Holliday*, 498 U.S. 52 (1990), which "read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *Id.* at 61.

on *all* stop-loss insurance policies. Thus, the Maryland law that the court of appeals below struck down would certainly be upheld by the Sixth Circuit.

Rather than attempt to reconcile its views with either *Michigan United Food* or *Northern Group*, the court of appeals for the Fourth Circuit has explicitly rejected those decisions. Indeed, in stating that a plan's purchase of stop-loss insurance does not save a State's insurance law from pre-emption, App. 6a-7a, the court of appeals below cited its earlier decision in *Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649 (4th Cir.1991), in which the court there noted -- and then refused to follow -- *Northern Group* and held instead that the purchase of "stop-loss insurance does not convert [an employer's] self-funded employee benefit plan into an insured plan." 928 F.2d at 653. In reaching this decision, the court in *Thompson* rejected the contrary holding of the court of appeals for the Sixth Circuit in favor of the Ninth Circuit's "persuasive" reasoning in *Moore v. Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir.1986), and *United Food and Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir.1986), in which the court of appeals in those cases found that an ERISA plan that purchases stop-loss insurance constitutes an uninsured plan covered by the deemer clause.[5]

As one commentator recently noted, "[t]he current confusion and disagreement among the circuit and district courts have caused uncertainty for state regulators, employers and their plans, plan participants, and courts,

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[5] Noting this conflict between the decisions of the courts of appeals for the Sixth and Ninth Circuits, Judge Brown in his dissenting opinion in *Brown v. Granatelli*, 897 F.2d 1351, 1357 n.5 (5th Cir.), *cert. denied*, 498 U.S. 848 (1990), stated that "the better reasoned approach is that adopted by the Sixth Circuit...."

especially those courts that have not yet considered the issue of stop-loss insurance." Paredes, *Stop Loss Insurance, State Regulation and ERISA: Defining the Scope of Federal Preemption*, 34 Harv. J. on Legis. at 258. *See also* Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance On Self-Insured Health Plans*, 14 Va. Tax. Rev. 615, 616 (1995) ("Despite the prevalence of such health coverage. . . regulation of such plans remains hopelessly muddled."). Moreover, the explosive growth of stop-loss insurance as a means of covering employee claims has significantly exacerbated the uncertainty and confusion surrounding this issue. The time is ripe to resolve this conflict among the federal appellate courts and to decide whether ERISA prohibits the States from regulating stop-loss insurance.

CONCLUSION

For the reasons stated, this Court should issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit. Following review, the judgment should be reversed.

Respectfully submitted,

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PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

AMERICAN MEDICAL SECURITY, INCORPORATED; CLIENT FIRST BROKERAGE SERVICES, INCORPORATED; MARAN, INCORPORATED; TRIO METAL PRODUCTS COMPANY, INCORPORATED; UNITED WISCONSIN LIFE INSURANCE COMPANY,
Plaintiffs-Appellants,

v.

No. H-95-1446

DWIGHT K. BARTLETT, III, in his capacity as Insurance Commissioner of the State of Maryland,
Defendant-Appellee

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; NATIONAL EMPLOYEE BENEFITS INSTITUTE; SELF-INSURANCE INSTITUTE OF AMERICA, INCORPORATED,
Amici Curiae.

Appeal from the United States District Court
for the District of Maryland, at Baltimore.
Alexander Harvey II, Senior District Judge.
(CA-95-1463-H)

Argued: October 28, 1996

Decided: April 11, 1997

Before NIEMEYER and MOTZ, Circuit Judges, and DOUMAR, Senior United States District Judge for the Eastern District of Virginia, sitting by designation.

Affirmed by published opinion. Judge Niemeyer wrote the opinion, in which Judge Motz and Senior Judge Doumar joined.

COUNSEL

ARGUED: Dennis William Carroll, Jr., Assistant Attorney General, MARYLAND INSURANCE ADMINISTRATION, Baltimore, Maryland, for Appellant. Edward J. Birrane, Jr., EDWARD J. BIRRANE, JR., CHARTERED, Towson, Maryland, for Appellees. **ON BRIEF:** J. Joseph Curran, Jr., Attorney General, Christina Gerstung Beusch, Assistant Attorney General, MARYLAND INSURANCE ADMINISTRATION Baltimore, Maryland, for Appellant. Andrew Jay Graham, Kathleen A. Birrane, KRAMON & GRAHAM, P.A., Baltimore, Maryland, for Appellees. Gregory B. Stites, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, Kansas City, Missouri, for Amicus Curiae Association. Joseph Semo, REINHART, BOERNER, VAN DEUREN, NORRIS & RIESEL- BACH, P.C., Washington, D.C., for Amicus Curiae Employee Benefits Institute. John H. Eggersten, Michael J. Friedman, HONIGMAN, MILLER, SCHWARTZ & COHN, Detroit, Michigan, for Amicus Curiae Self-Insurance Institute.

OPINION

NIEMEYER, Circuit Judge:

We must decide whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, preempts a Maryland insurance regulation that fixes the minimum attachment point for stop-loss insurance policies issued to self-funded employee benefit plans covered by ERISA. *See* Code of Maryland Regulations (hereafter "COMAR"), §9.31.02 (Health Insurance - Stop-

Loss Coverage). The state regulation is designed to prevent insurers and self-funded employee benefit plans from depriving plan participants and beneficiaries of state mandated health benefits. *See* 22 Md. Reg. 913 (1995).

The district court entered summary judgment declaring that ERISA preempts the state regulation and that the regulation is, therefore, "void to the extent that it mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA." The Court also enjoined Maryland from enforcing the regulation or taking any other step "to regulate or affect the attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans."

Because the purpose and effect of Maryland's regulation is to force state-mandated health benefits on self-funded ERISA plans when they purchase certain types of stop-loss insurance, we hold that § 514(a) of ERISA, 29 U.S.C. § 1144(a), preempts the regulation, and, therefore, we affirm.

I.

Client First Brokerage Services, Incorporated; Maran, Incorporated; and Trio Metal Products Company, Incorporated, are Maryland employers sponsoring self-funded employee health benefit plans subject to ERISA. Each has purchased stop-loss insurance from United Wisconsin Life Insurance Company ("United Wisconsin Life") and has engaged American Medical Security, Incorporated, ("AMS") as administrator of their plans. These Maryland employers purchased stop-loss insurance to cover their plans' benefit payments above an annual

$25,000-per-employee level, known as the "attachment point." United Wisconsin Life was also agreeable to a lower attachment point, insuring a greater portion of the plans' payments, if requested to do so by the plans' sponsors. The stop-loss insurance afforded by United Wisconsin Life protected the plans themselves and not their participants or beneficiaries.

The employee benefit plans sponsored by these three Maryland employers contained substantially fewer benefits than the 28 mandated by Maryland for health insurance policies regulated by the Maryland Insurance Commissioner. *See* COMAR, § 09.31.05.03. The benefit plans sponsored by these Maryland employers did not, for example, include benefits for skilled nursing facility services, outpatient rehabilitative services, and certain organ transplants, all of which are mandated for inclusion in Maryland health insurance policies.

In the course of its review of United Wisconsin Life stop-loss policies in the fall of 1994 - insurance companies issuing policies to Maryland residents are required to obtain prior approval for their policies, *see* Md. Code, art. 48A, §§ 242 & 375 - the Maryland Insurance Agency disapproved United Wisconsin Life's stop-loss policies issued to the Maryland employers in this case because the attachment point was set informally at $25,000 and could be reduced at the employer's request. Since the policy could have an attachment point below $25,000 (the then mandated minimum), it was considered a policy of health insurance and, as such, was required to include mandated health benefits. *See* COMAR, §§ 9.31.02 & 9.31.05. Subsequently, the Maryland Insurance Commissioner dropped the minimum attachment point for stop-loss insurance to $10,000 of benefits paid to any single

beneficiary annually. The Commissioner also imposed a minimum aggregate attachment point of 115% of total benefit payments expected to be paid to all plan beneficiaries. COMAR, § 9.31.03B.

The Maryland employers, United Wisconsin Life, and AMS filed suit seeking a declaratory judgment that the regulations are not enforceable and an injunction against their enforcement. They alleged that Maryland's insurance regulations - which (1) establish a minimum attachment point for stop-loss insurance, and (2) deem stop-loss insurance policies with lower attachment points to be health insurance policies - improperly sought to regulate employee benefit plans in violation of ERISA's preemption provision. On cross motions for summary judgment, the district court agreed with the plaintiffs and
declared that ERISA preempts Maryland's regulations. This appeal followed.

II.

This case presents the tension between Maryland's effort to guarantee through its regulation of insurance that employee benefit plans offer at least 28 state-mandated health benefits, *see* COMAR, § 09.31.05, and Congress' preemption, through ERISA, of any state regulation that "relates to" an employee benefit plan, *see* 29 U.S.C. § 1144(a).

ERISA is a comprehensive federal statute regulating private employee benefit plans, including plans maintained for the purpose of providing medical or other health benefits for employees. To assure national uniformity of federal law, ERISA broadly preempts state law and assures that federal regulation will be exclusive. Section 514(a)

provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" as defined by ERISA. The courts have interpreted this clause broadly to carry out Congress' purpose of displacing any state effort to regulate ERISA plans. *See, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) ("The preemption clause is conspicuous for its breadth"); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98 (1983) ("The section's preemptive scope [is] as broad as its language"). Thus, any law that "relates to" a plan is preempted by § 514(a), and the phrase "relates to" is given its common sense meaning, as having "[1] connection with or [2] reference to such a plan." *Shaw*, 463 U.S. at 96-97; *see also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992).

Although ERISA'S preemptive scope is broad, the "savings clause" explicitly saves from ERISA's preemption those state laws that regulate insurance. *See* 29 U.S.C. § 1144(b)(2)(A). At the same time, however, the "deemer clause" provides that state insurance laws are not saved from preemption if they deem an employee benefit plan to be an insurance company in order to regulate it. *See* 29 U.S.C. § 1144(b)(2)(B); *see also Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Thus, a preempted law is saved from preemption if it regulates insurance and does not deem ERISA plans to be insurers for purposes of the state regulation of insurance. But at bottom, state insurance regulation may not directly or indirectly regulate self-funded ERISA plans. *See FMC*, 498 U.S. at 62. Accordingly, although plans that provide benefits in the form of insurance may be indirectly regulated through regulation of that insurance, *see id.* at 62-64, plans that are self-funded or self-insured may not themselves be regulated as insurance companies even if the self-funded or self-

insured plan purchases stop-loss insurance to cover losses or benefits payments beyond a specified level. *See Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994); *Thompson v. Talquin Bldg. Prods. Co.*, 928 F.2d 649, 653 (4th Cir. 1991).

Stop-loss insurance provides coverage to self-funded plans above a certain level of risk absorbed by the plan. It provides protection to the plan, not to the plan's participants or beneficiaries, against benefit payments over the specified level, called the "attachment point." Attachment points may be "specific" or "aggregate." Specific attachment points define the level of benefits paid to individual beneficiaries beyond which the insurance company will indemnify the plan. Aggregate attachment points define the total number of benefits paid to all participants or beneficiaries beyond which the insurance company will indemnify the plan. Stop-loss insurance is thus akin to "reinsurance" in that it provides reimbursement to a plan after the plan makes benefit payments. *See* COMAR, § 09.31.02.02(5); *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 723 (2d Cir.), *rev'd on other grounds*, 115 S.Ct. 1671 (1994); *Thompson*, 928 F.2d at 653.

The State of Maryland regulates health insurance, requiring that health insurance policies afford at least 28 specified benefits. *See* COMAR, § 09.35.05. Apparently not wishing to be subject to state-mandated health benefits, insurance companies and their ERISA plan clients have entered into arrangements under which plans self-fund benefits and purchase stop-loss insurance to insure themselves against benefits paid beyond designated attachment points. A stop-loss policy does not itself provide coverage for benefits. Since such a policy insures only those benefits defined and actually paid by the plan, the ERISA plan's sponsor, not

state health insurance regulations, dictates the range of benefits provided. Thus, by absorbing a minimal amount of initial risk and insuring the remainder through stop-loss insurance, plans are able to provide health benefits of a kind or at a level different from what state law requires of health insurance.

Recognizing that such arrangements bypass Maryland's regulations for health insurance and intending to prevent such arrangements, the Maryland Insurance Commissioner adopted regulations that require plans to absorb the risk of at least the first $10,000 of benefits paid to each beneficiary. As the regulations' statement of purpose notes, the Commissioner seeks to protect Maryland residents "against acts by persons and insurers which deprive them of mandated health benefits." 22 Md. Reg. 913 (1995). Justifying the regulation and explaining how low attachment points permit self-funded ERISA plans to bypass state mandates, the Insurance Commissioner stated in his order:

> At very low attachment points, however, a "stop loss" policy is merely a substitution for health insurance. It does not insure only against catastrophic loss. The self-funded health benefit plan is not regulated by the Insurance Commissioner and is not required to provide any of the state-mandated benefits. The goal is obvious: As policies become available with attachment points lower than many deductibles, it became an increasingly attractive option to "self-insure" a health plan, but to continue to shift the majority of the risk to the insurance carrier by purchasing "stop-loss" coverage.

In re: Maryland Stop Loss Insurance Litigation, No. MIA-370-12195 at 4 (Dec. 8, 1995). The regulations accordingly

provide that any stop-loss insurance policy with a specific attachment point below $10,000 is deemed to be a health insurance policy for purposes of Maryland's health insurance regulations and must therefore contain mandated benefits. *See* COMAR § 09.31.02.03. On the other hand, if the specific attachment point is above $10,000 and the policy provides for payment only to the plan, and not to its participants and beneficiaries, it is considered to be traditional stop-loss insurance that essentially reinsures the risks defined by the plan. *See id.*

In summary, on one side of the issue before us, the Maryland Insurance Commissioner seeks to take advantage of his right under ERISA's savings clause to regulate the business of insurance. And on the other side, the insurance companies seek to take advantage of ERISA's preemption and deemer clauses to remove self-funded plans from the reach of state insurance regulation.

III.

We begin the analysis with the question of whether Maryland's regulations "relate to" ERISA employee benefit plans and thus whether they fall within ERISA's preemptive scope. *See* 29 U.S.C. § 1144(a). A regulation relates to an employee benefit plan when it has a "connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. The Maryland Insurance Commissioner wisely concedes that the regulations at issue do "relate to" ERISA plans. By their own terms, the stop-loss insurance regulations apply to "an employer's health plan," *i.e.*, an ERISA health plan. *See* COMAR, § 09.31.02.02(4). "[W]here the existence of ERISA plans is essential to the [state] law's operation, . . . that 'reference' will result in preemption." *California Div'n of Labor Standards Enforcement v. Dillingham Constr.*,

N.A., 117 S.Ct. 832, 838 (1997) (noting that state law that "has a connection with" or "reference to" an employee benefit plan is preempted). By virtue of the regulations' "reference to" ERISA plans, they "relate to" ERISA plans and fall within the scope of ERISA's preemption provision, 29 U.S.C., § 1144(a). *See Greater Washington Bd. of Trade*, 506 U.S. at 129.

Even though Maryland's regulations relate to ERISA plans, they nevertheless may be saved from preemption if they constitute a law that "regulates insurance," *see* 29 U.S.C. § 1144(b)(2)(A), without deeming an ERISA plan to be an insurance company or other insurer, *see* 29 U.S.C. § 1144(b)(2)(B). In determining whether a state law is one that "regulates insurance," it is not enough that it operate only on insurance companies or insurance policies. The regulation must regulate the business of insurance in the sense that the object of its regulation (1) "has the effect of transferring or spreading a policyholder's risk"; (2) "is an integral part of the policy relationship between the insurer and the insured"; and (3) "is limited to entities within the insurance industry." *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 743 (1985).

In this case, the Maryland Insurance Commissioner can well argue with respect to the first *Metropolitan Life* factor that the setting of attachment points allocates risk. Higher attachment points burden plans with more risk while lower attachment points increase insurance company risk. The Commissioner might also be able to argue successfully on the second *Metropolitan Life* factor that the regulations address a practice integral to the insured-insurer relationship, at least if our analysis is limited to the explicit terms of the regulations. The regulations, by their own terms, seek to impose requirements only on insurance

companies and their stop-loss insurance policies. This factor is, however, complicated by the fact that the intended, stated, and actual effect of the regulations is to reach the relationship between ERISA plans and their participants who are not parties to the insurance contract. The third *Metropolitan Life* factor is complicated in the same way. Although the state's regulation of attachment points is limited to entities in the insurance industry, the stated purpose of the regulations is also to reach the plan-participant relationship, a relationship which is outside the insurance industry.

While the Maryland Insurance Commissioner can thus make a superficial case that the regulations address the business of insurance, the complications of the second and third *Metropolitan Life* factors together with the "deemer clause" provide the core difficulty with the state's regulation of stop-loss insurance policies issued to ERISA plans.

We recognize that the regulations are carefully drafted to focus directly on insurance companies issuing stop-loss insurance and not on the employee benefit plans themselves. Thus, the regulations purport to define stop-loss insurance as health insurance subject to state regulation if the stop-loss insurance meets specific criteria. Notwithstanding the regulations' wording, however, their purpose and effect are directed at self-funded employee benefit plans that attempt to provide fewer health benefits to Maryland residents than state law mandates for health insurance policies. The state asserts a need for this regulation because, in its absence, the loophole would allow every self-funded plan to provide coverage for fewer health benefits than state law mandates for health insurance policies. It argues that absorbing a minimal risk is simply

a sham to circumvent state insurance regulation, the area carved out by ERISA in which states may act. But in seeking to address this perceived loophole, the state in fact ends up regulating self-funded employee benefit plans that are exclusively subject to ERISA.

In seeking to require self-funded plans to offer coverage consistent with state insurance law, Maryland crosses the line of preemption. Even though the regulatory language targets stop-loss insurance policies, the Commissioner's stated purpose is to protect Maryland residents from self-funded ERISA plans and insurers "which deprive them of mandated health benefits." 22 Md. Reg. 913 (1995). The regulations thus use stop-loss insurance policies as a vehicle to impose the requirements of Maryland health insurance law on self-funded ERISA plans. By aiming at the plan-participant relationship, Maryland law violates the ERISA provision that no ERISA plan "shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. § 1144(b)(2)(B).

The state's fear that plans will circumvent state regulation and offer citizens too few health benefits is understandable. But to state that fear reveals that Maryland is really concerned, not with the business of insurance and its coverage of risks, but with the benefits that ERISA plans can choose to provide their participants and beneficiaries. No matter how understandable this concern may be, only Congress may address it, not the State of Maryland through its insurance regulations. In attempting to address this concern through the regulation of stop-loss insurance, the state blurs the real distinction between self-funded plans, with or without stop-loss insurance, and fully insured plans.

Maryland's regulations distinguish self-funded plans from insured plans solely based on the level of the attachment point of stop-loss insurance. Thus, when the attachment point becomes low, Maryland deems self-funded plans with stop-loss insurance to be insured plans. *See* COMAR, § 09.35.02.02. This distinction overlooks the real risks.

Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan's terms. That liability remains the employer's even if it has purchased stop-loss insurance and even if the stop-loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop-loss insurer may not benefit plan participants and beneficiaries. This is because their claims against the insurer would be derivative of the plan's claim against the insurer, which arises only after the plan actually makes benefit payments beyond the agreed attachment point. In contrast, when a plan buys health insurance for participants and beneficiaries, the plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefits even in the event of the plan's insolvency. Participants and beneficiaries in self-funded plans may not have the security of the insurance company's assets because stop-loss insurance insures the plan and not the participants.

The state's regulations fail to recognize that in a self-funded plan, with or without stop-loss insurance and regardless of the attachment point, the provision of benefits depends on the plan's solvency, whereas the provision of benefits in an insured plan depends entirely on the insurer's solvency. It is this fundamental difference that precludes the Maryland Insurance Agency from regulating self-funded plans but permits them to regulate insurance companies that

provide health benefits to plans for their participants. While ERISA's savings clause explicitly empowers states to adjust the obligations and incentives which bear on insurance companies' solvency, *see* 29 U.S.C. § 1144(b)(2)(A), the combined effect of the preemption and deemer clauses, 29 U.S.C. § 1144(a) & (b)(2)(B), is that ERISA plan solvency is the purview of federal law alone.

Maryland's stop-loss insurance regulations also directly and impermissibly affect ERISA plans' costs and choices in designing their own array of benefits. If a self-funded plan insured by stop-loss insurance having an attachment point of $5,000 provided no benefit for organ transplants, the regulations would either raise plan costs by including unwanted, state-mandated insurance coverage for organ transplants or convert the self-funded plan into a fully insured plan contrary to its preference. These effects impermissibly intrude on the relationship between an ERISA plan and its participants and beneficiaries.

While we recognize that self-funded plans may not be providing Maryland residents with the range of benefits mandated by state law and that such plans' benefits may not always be as secure as those offered by regulated insurance companies, the remedy for any such deficiency must be requested of Congress. When ERISA preempted state law relating to ERISA-covered employee benefit plans, it may have created a regulatory gap, but Maryland is without authority to fill that gap. *See Greater Washington Bd. of Trade*, 506 U.S. at 130-31 (D.C. workers' compensation provision requiring the provision of benefits in proportion to covered benefits to ERISA plan "relates to" and is therefore preempted by ERISA); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981) ("even indirect state action bearing on [ERISA plans] may encroach upon

the area of exclusive federal concern"). This is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states. *See* 15 U.S.C. § 1012(a) (The "business of insurance, and every person engaged therein, shall be subject to the laws of the several states"); 29 U.S.C. § 1144(b)(2) (ERISA does not preempt "any law of any State which regulates insurance" unless it deems a plan to be "an insurance company"). But because the Maryland regulation before us attempts to mandate the benefits that certain self-insured plans may offer, we affirm the judgment of the district court.

AFFIRMED

FILED: May 6, 1997

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 96-1376
CA-95-1463-H

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MARAN, INC.; TRIO METAL PRODUCTS COMPANY, INC.; UNITED WISCONSIN LIFE INSURANCE COMPANY

Plaintiffs - Appellees

v.

DWIGHT K. BARTLETT, III, in his capacity as Insurance Commissioner of the State of Maryland

Defendant - Appellant

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; NATIONAL EMPLOYEE BENEFITS INSTITUTE; SELF-INSURANCE INSTITUTE OF AMERICA, INC.

Amici Curiae

No. 96-1446
CA-95-1463-H

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MARAN, INC.; TRIO METAL PRODUCTS COMPANY, INC.; UNITED WISCONSIN LIFE INSURANCE COMPANY

Plaintiffs - Appellants

v.

DWIGHT K. BARTLETT, III, in his capacity as Insurance Commissioner of the State of Maryland

Defendant - Appellee

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Amicus Curiae

and

NATIONAL EMPLOYEE BENEFITS INSTITUTE; SELF-INSURANCE INSTITUTE OF AMERICA, INC.

Amici Curiae

On Petition for Rehearing with Suggestion for Rehearing in Banc

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The appellants' petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Patricia S. Connor

Clerk

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MORAN, INC.; TRIO METAL PRODUCTS COMPANY, INC., AND UNITED WISCONSIN LIFE INSURANCE COMPANY	:	
Plaintiffs,	:	
	:	Civil No. H-95-1463
vs.	:	
DWIGHT K. BARTLETT, III, Commissioner, Maryland Insurance Administration,	:	
Defendant.	:	

HARVEY, Senior District Judge

DATED: February 23, 1996

Edward J. Birrane, Jr., Towson, Md., and Andrew Jay Graham and Kramon and Graham, Baltimore, Md., for plaintiffs.

Christina Gerstung Beusch, Assistant Attorney General, Baltimore, Md., for defendant.

In this civil action, the plaintiffs challenge a regulation ("the Regulation") promulgated by defendant Dwight K. Bartlett, III, Commissioner of the Maryland Insurance Administration ("the Commissioner"). The parties have undertaken discovery, and both the plaintiffs and the defendant have filed a motion for summary judgment.

The question of law presented by the pending motions is whether the Regulation, which concerns so-called "stop-loss" insurance issued by insurers to employee benefit plans, is preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001, et seq. The five plaintiffs have here filed a three-count complaint, seeking injunctive and declaratory relief. Plaintiffs ask the Court to enter a judgment declaring (1) that ERISA preempts the Commissioner and the State of Maryland from enforcing any regulation or statute, or any decision or action having the effect of law, as respects any stop-loss policy issued to an employee benefit plan covered by ERISA, and (2) that the Commissioner and the State of Maryland are preempted from regulating the so-called attachment points of stop-loss insurance policies.[1] Plaintiffs also seek an award of attorneys' fees and costs.

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[1] In Count Three of their complaint, plaintiffs also seek an injunction and a judgment declaring that defendant's attachment point requirements are unenforceable under Maryland law. Plaintiffs have not, however, sought summary judgment as to this Count. At the hearing held on the pending motions, counsel for plaintiffs indicated that they would agree to a dismissal without prejudice of Count Three, if their motion for summary judgment were granted as to Counts One and Two.

In support of their motions, the parties have submitted lengthy memoranda and numerous exhibits. A hearing has been held in open court. For the reasons to be stated herein, plaintiffs' motion for summary judgment will be granted, and defendant's motion for summary judgment will be denied. Count Three of the complaint will be dismissed without prejudice.

I.

Employee Benefit Plans Under ERISA

An "employee benefit plan" under ERISA includes a plan established or maintained by an employer to the extent that such plan was established or is maintained for the purpose of providing for its participants or their beneficiaries, medical, surgical, or hospital care or benefits. 29 U.S.C. § 1002(1). A plan may be fully insured, self-insured, self-funded, or a combination thereof. A fully insured plan purchases a group health insurance policy in order to fund its benefits. A self-funded plan pays benefits out of a pool of money collected from the plan's own funds, from employee contributions, or from both. A self-insured plan also pays benefits out of its own funds, but the money comes from the employer's general funds and not from a separate pool.[2]

Self-insured and self-funded plans often purchase so-called "stop-loss" insurance in order to limit the financial risk which the plan might face in the event of catastrophic

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[2] For purposes of the pending motions, there is no distinction between a self-funded plan and a self-insured plan.

health care expenses. Stop-loss insurance reimburses the employee benefit plan for claims that exceed a certain agreed-upon amount, the so-called "attachment" point. There are two types of attachment points: specific (or individual) and aggregate. A specific attachment point represents the amount above which the stop-loss carrier must reimburse the plan for eligible claims made by an individual plan participant during the plan year. The specific attachment point protects the plan against exceptionally high claims made by an individual participant. An aggregate attachment point represents the amount above which the stop-loss carrier must reimburse the plan for all eligible claims during the plan year.[3] The aggregate attachment point protects the plan against the risk of higher than expected total claims made by plan participants.

Stop-loss coverage insures the employee benefit, plan, not the individual participants in the plan. Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991). Therefore, the purchase of stop-loss insurance does not relieve the plan of its obligation to pay benefits to plan participants, and the stop-loss insurer has no obligation to pay claims of plan participants. Id. Moreover, the purchase of stop-loss insurance does not convert a self-funded or self-insured employee benefit plan into a fully insured plan for preemption purposes. Id.; Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309, 315 (4th Cir. 1994), cert. denied, 115 S.Ct. 1175 (1995). For the purposes of ERISA, a plan remains self-funded even though covered by stop-loss insurance. Id.

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[3] The aggregate attachment point is typically expressed as a percentage of total expected claims, but may be a specific dollar amount.

II.

Background Facts

The Regulation at issue in this case was propounded by defendant Dwight K. Bartlett, III, in his official capacity as Insurance Commissioner of the State of Maryland. Plaintiffs are American Medical Security, Inc. ("AMS"), Client First Brokerage Services, Inc. ("Client First"), Moran, Inc. ("Moran"), Trio Metal Products Company, Inc. ("Trio Metals"), and United Wisconsin Life Insurance Company ("UWLIC"). UWLIC is licensed and authorized to engage in the business of life and health insurance in the State of Maryland. UWLIC sells stop-loss coverage to self-funded and self-insured employee benefit plans. AMS is a licensed third-party administrator which processes health benefit claims on behalf of self-funded plans that have purchased stop-loss insurance from UWLIC. Client First, Moran and Trio Metals are Maryland corporations which maintain self-funded plans, and each of these small employers has purchased from UWLIC stop-loss insurance administered by AMS. The specific attachment point of the stop-loss policy issued to Client First is $25,000, the Moran specific attachment point is $3,000, and the Trio Metals specific attachment point is $2,500.[4]

The stated purposes of the Regulation are to define when stop-loss coverage will be considered to be health insurance, and to establish that the purpose of true stop-loss coverage is to cover catastrophic losses of the policyholder.

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[4]Due to enrollment additions, terminations, and changes, the aggregate attachment point under each policy cannot be calculated until the end of the plan year.

COMAR § 09.31.02. Essentially, the Regulation defines "stop-loss insurance" by setting out certain requirements for an insurance policy to qualify as such. Among these requirements are that, if a policy contains a specific attachment point, it must be at least $10,000 per participant per year, and that if the policy contains an aggregate attachment point, it must be at least 115% of expected claims for all participants. COMAR § 09.31.02.03B. A stop-loss policy need not contain both type of attachment points, but the attachment point which it does contain must meet the minimum requirements of the Regulation.

A "stop-loss" policy which does not satisfy the minimum requirements of the Regulation is considered to be a standard health insurance policy, required by Maryland law to provide specific benefits.[5] Thus, the Regulation attempts to prevent small employers like Client First, Moran and Trio Metals from avoiding the minimum health insurance coverage required by Maryland law. If a stop-loss policy issued to such an employer contains a low attachment point, then the stop-loss coverage attached at a very early time, and the stop-loss carrier essentially acts as a typical insurer the obligations of which arise after a specified deductible is satisfied. In this manner, a self-funded or self-insured plan bears very little responsibility for making benefit payments itself, and at the same time it

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[5] Under the Maryland Health Insurance Reform Act of 1993, the only health insurance which may be sold to an employer having between two and fifty employees is the Comprehensive Standard Health Benefit Plan established by the Act. Md. Ann. Code art. 48A §§ 698-713. This standard plan contains some 37 required benefits. COMAR §§ 09.31.05.01-.11.

avoids the minimum coverage mandated by Maryland law.[6] As intended, the effect of the Regulation is to force a small employer to either bear more risk by means of the adoption of a higher attachment point, or to abandon self-funding and purchase a health insurance policy which would include state-mandated coverage. Plaintiffs contend that a third option exists, namely that a self-funded plan might decide not to purchase stop-loss insurance, and thereby risk insolvency if forced to pay exceptionally high claims.

III.

Discussion

ERISA in general preempts "any and all State laws" insofar as they "relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). However, a state law "which regulates insurance, banking or securities" is not preempted, pursuant to the so-called "saving clause" of ERISA. 29 U.S.C. § 1144(b)(2)(A). The "saving clause" is in turn limited by the so-called "deemer clause," which provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . ." 29 U.S.C. § 1144(b)(2)(B).

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[6] According to the Commissioner, the current Moran plan provides 9 of the 37 required benefits, and the current Trio Metals plan provides 15 of the 37 required benefits. No analysis of the Client First plan was done because the $25,000 specific attachment point in that policy would satisfy the definition of "stop-loss insurance" in the Regulation.

The Supreme Court has explained that ERISA's preemption clause

> establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States power to enforce those state laws that "regulate[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990). In a number of cases, the Supreme Court has noted the exceptional breadth of preemption under ERISA. See, e.g., id.; Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 90 (1983).

(a)

Does the Regulation "Relate To" an Employee Benefit Plan?

Initially, this Court must determine whether the Regulation "relates to" an employee benefit plan covered by ERISA. A law "relates to" an employee benefit plan if it has a "connection with or reference to" such a plan. Shaw, 463 U.S. at 97. The Court in this case must therefore first determine whether the Regulation refers to employee benefit plans, or is connected to such plans, and accordingly

is subject to preemption under § 1144(a).

The Supreme Court has "virtually taken it for granted that state laws which are 'specifically designed to affect employee benefit plans' are preempted under [§ 1144(a)]." Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 829 (1988). In pertinent part, the Regulation states:

> A policy or contract issued to an employer may be considered to be a policy or contract of stop-loss health insurance coverage only if:
>
> (1) The stop-loss coverage is issued to and insures the sponsor or administrator of the plan or the plan itself and is not issued to employees, dependents, members, or participants;
>
> (2) The carrier is liable for payment only to the sponsor or administrator of the plan or the plan itself and not to the employees, dependents, members, subscribers, participants, or providers . . .

From its review of this portion of the Regulation, this Court concludes that the quoted language appears to be "specifically designed to affect employee benefit plans," especially in light of the Commissioner's statement that a purpose of the Regulation is to limit the amount of risk that a self-funded plan can cede to its stop-loss insurer. Such a limitation is aimed at preventing small employers from self-funding their plans in order to avoid state mandated benefits.

In arguing that the Regulation does not "relate to" an ERISA plan, defendant relies on the recent Supreme Court decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Ins. Co., 115 S.Ct. 1671 (1995). But the facts of that case are distinguishable from those present here. The Supreme Court in Travelers criticized the broad definition of "relates to" in Shaw, and ultimately found that the surcharge system at issue in that case had no "connection with" employee benefit plans because it merely had an indirect economic effect on the relative costs of various health insurance packages available to plan administrators. Id. at 1680. In the present case, however, the Regulation applies specifically to stop-loss insurance sold only to benefit plans. Here, there is a much greater connection between the Regulation and an ERISA benefit plan than existed under the more generally applicable surcharge system in Travelers. The Regulation at issue in this case thus goes well beyond the indirect effects of the surcharge system in Travelers and imposes significant restrictions on plan administration and operation.

On the record here, this Court concludes that the Regulation was designed to affect employee benefit plans, that it therefore "relates to" an ERISA plan and that it is subject to preemption under § 1144(a).

(b)

Is the Regulation "Saved" from Preemption?

Because the Regulation relates to an employee benefit plan, it is preempted unless it falls within the "saving clause" and does not violate the "deemer clause." In general, a state law is protected by the "saving clause" if it

"regulates insurance." 29 U.S.C. § 1144(b)(2)(A). However, this protection is lost if the law, in purporting to regulate insurance, deems a plan to be "an insurance company or other insurer . . . or to be engaged in the business of insurance. . ." 29 U.S.C. § 1144(b)(2)(B). Although the parties have discussed in great detail the various tests to be applied by a court in determining whether a state law "regulates insurance," applicable case law indicates that because of the "deemer clause," the "saving clause" does not under the circumstances of this case protect the Regulation from preemption.

The Regulation "directly controls the terms of insurance contracts" by mandating, inter alia, minimum attachment points in order for a policy to be considered stop-loss insurance. See FMC Corp., 498 U.S. at 61. The Regulation therefore would typically fall within the protection of the "saving clause" and not be preempted, as long as it did not violate the "deemer clause." The Fourth Circuit, however, has held that "[a]lthough under the 'saving clause,' any state law regulating insurance policy terms withstands ERISA preemption, self-funded employee benefit plans are not covered by the clause." Thompson, 928 F.2d at 649, citing FMC Corp., 498 U.S. at 61; Metropolitan Life, 471 U.S. at 747; Powell v. Chesapeake and Potomac Tel. Co. of Va., 780 F.2d 419, 423 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986). This Court therefore concludes that in this particular case the "saving clause" is inapplicable, and the Regulation is preempted because of the interaction between the "saving clause" and the "deemer clause."

As stated by the Supreme Court,

> We read the deemer clause to exempt self-funded ERISA plans from state laws that "regulat[e]

> insurance" within the meaning of the saving clause. By forbidding States to deem employee benefit plans "to be an insurance company or other insurer . . . or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are preempted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

FMC Corp., 498 U.S. at 61.

As the Supreme Court has recognized, fully insured plans are not subject to ERISA preemption.

> On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. As the Court explained, "the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it."[7] Id. at 64. Plaintiffs assert that the self-funded plans of Client First, Moran, and Trio Metals are uninsured and therefore not subject to state regulation. This Court would agree.

Defendant argues that, because the plans at issue here purchase stop-loss insurance, they are subject to indirect regulation to the same extent as fully insured plans. According to defendant, the Regulation controls the terms of insurance policies, which is a permissible means of regulating an insured plan. See id. at 61; Metropolitan Life, 471 U.S. at 746-47. Defendant focuses on the fact that the plans in fact purchase insurance, and argues that they must therefore be considered to be insured and subject to indirect regulation, whether or not they are primarily self-funded.

Whatever plausibility such an argument may have, the Court must reject it under applicable Fourth Circuit law. While it is true that the Client First, Moran, and Trio Metals plans purchase insurance, those plans are not considered "insured" plans as that term has been construed in ERISA cases. The Fourth Circuit has specifically held that "stop-

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[7]Although the Supreme Court has recognized that, for purposes of a preemption issue, there exists a distinction between insured and uninsured plans, "leaving the former open to indirect regulation while the latter are not . . .", the Court has further observed that "[a]rguments as to the wisdom of these policy choices must be directed at Congress." Metropolitan Life, 471 U.S. at 747.

loss insurance does not convert [a] self-funded employee benefit plan into an insured plan." Thompson, 928 F.2d at 653; see also Tri-State Mach., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309, 315 (4th Cir. 1994), cert. denied, 115 S.Ct. 1175 (1995); United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga, 801 F.2d 1157, 1161-62 (9th Cir. 1986). There is a distinction between a group health insurance policy purchased by a fully insured plan, whereby the participants receive benefit payments directly from the insurer, and a stop-loss insurance policy purchased by a self-funded or self-insured plan, whereby the plan itself receives the benefit payment. The purpose of stop-loss insurance is to protect the plan from catastrophic losses and not to provide health and accident insurance directly to employees. Thompson, 928 F.2d at 653. Accordingly, this Court concludes that the self-funded plans at issue in this case cannot be considered to be insured and subject to indirect State regulation for purposes of determining whether there is ERISA preemption.

In sum, the Regulation directly regulates insurance and therefore would be "saved." However, applying principles enunciated by the Supreme Court and the Fourth Circuit, the Regulation cannot reach the self-funded plans of plaintiffs Client First, Moran, and Trio Metals because those plans may not be deemed to be insurance companies or other insurers. See FMC Corp., 498 U.S. at 61. "State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." Id. Moreover, the purchase of stop-loss insurance does not strip the plans of their self-funded status. Thompson, 928 F.2d at 652-53; Tri-State

Mach., 33 F.3d at 315.

For these reasons, the Court concludes that the State of Maryland may not regulate the self-funded and self-insured benefit plans at issue in this case by mandating minimum attachment points for stop-loss insurance. The Regulation is therefore preempted by ERISA.

IV.

Attorneys' Fees and Costs

In their complaint, plaintiffs seek, inter alia, an award of attorneys' fees and costs under 29 U.S.C. § 1132(g)(1). That statute permits the court in its discretion to allow "a reasonable attorney's fee" and costs in an action brought by a participant, beneficiary, or fiduciary.

Neither plaintiffs nor defendant have addressed in their motions for summary judgment plaintiffs' claim for an award of attorneys' fees and costs. Only in plaintiffs' opposition to defendant's motion for summary judgment was this issue briefly discussed.

In Reinking v. Philadelphia Am. Life Ins. Co., 910 F.2d 1210, 1217-18 (4th Cir. 1990), the Fourth Circuit adopted a five factor test to be applied by a court in awarding attorneys' fees under ERISA. Since that test has not been adequately addressed by the parties in light of the circumstances here, the Court will not at this time rule on plaintiffs' request for an award of attorneys' fees. Plaintiffs should file an appropriate motion under Local Rule 109.2, seeking attorneys' fees and costs under § 1132(g)(i). That motion should then be briefed by the parties pursuant to

Local Rule 105.2. The Court will later determine whether plaintiffs are entitled to such an award and, if so, the amount to be awarded.

V.

Conclusion

For all the reasons stated, the Court will grant plaintiffs' motion for summary judgment as to Counts One and Two, and will dismiss, without prejudice, Count Three of the complaint. Defendant's motion for summary judgment will be denied. Plaintiffs should submit to the Court within 10 days a proposed declaratory judgment order. Plaintiffs should thereafter file an appropriate motion seeking attorneys' fees and costs pursuant to Local Rule 109.2.

Alexander Harvey, II
Senior United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

AMERICAN MEDICAL SECURITY, INC.; CLIENT FIRST BROKERAGE SERVICES, INC.; MORAN, INC.; TRIO METAL PRODUCTS COMPANY, INC., AND UNITED WISCONSIN LIFE INSURANCE COMPANY	:	
Plaintiffs,	:	
	:	Civil No. H-95-1463
vs.	:	
DWIGHT K. BARTLETT, III, Commissioner, Maryland Insurance Administration,	:	
Defendant.	:	

JUDGMENT

This matter having come before the Court for consideration of summary judgment motions filed in the above entitled case by all parties; and this Court having carefully reviewed briefs and exhibits submitted in support of and in opposition to the motions, and having heard oral argument from counsel for the parties thereon; and this Court having rendered its Opinion in this matter on February 23, 1996, it is this 12th day of March, 1996 by the United States District Court for the District of Maryland.

ORDERED:

1. That Count Three of the Complaint is dismissed without prejudice;

2. That the motion for summary judgment filed by the defendants as to Counts One, Two and Three of the Complaint is denied;

3. That the motion for summary judgment filed by the plaintiffs as to Counts One and Two of the Complaint is granted;

4. That Judgment is hereby entered in favor of plaintiffs, with costs; and

5. That pursuant to 28 U.S.C. §§ 2201 and 2202, it is the FINDING and DECLARATION of this Court that:

a. The Employee Retirement Income and Security Act ("ERISA"), 28 U.S.C. § 1001, et seq. (1979) preempts the Insurance Commissioner of the State of Maryland (and any other person authorized by the State of Maryland to promulgate any regulation, statute or any decision or action having the effect of law) from promulgating or enforcing, directly or indirectly, any regulation, statute or decision that mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA;

b. The regulation published as Code of Maryland Regulations ("COMAR") § 09.31.02 and entitled "Health Insurance-Stop-Loss Coverage" ("the Regulation") is preempted by ERISA and therefore is void to the extent that it mandates or affects attachment points for stop-loss

insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA; and

6. That defendant, the Insurance Commissioner and the State of Maryland and its agents, employees and officials are prohibited and ENJOINED from enforcing the Regulation or otherwise attempting, by any means, to regulate or affect the attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans that exist or are hereafter formed under the Employee Retirement Insurance Security Act of 1974, as amended.

Alexander Harvey, II
Senior United States District Judge

STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION

IN RE:	:	
MARYLAND STOP LOSS INSURANCE REGULATION	:	CASE NO. MIA-370-12/95

ORDER

I. Introduction

On June 9, 1995, the Maryland Insurance Administration published a proposed regulation in the Maryland Register, 22 Md. Reg. 913 (June 9, 1995). This regulation defines and distinguishes stop loss insurance and health insurance under the Insurance Code. As part of this definition, the regulation sets attachment points of $20,000 on an individual basis and 125% of expected claims on an aggregate basis for policies which are to be considered stop loss. On August 24, 1995, following the standard 30 day comment period during which written comments were received, the regulation was published as a final regulation with an effective date of September 24, 1995, to apply to all policies issued or renewed after January 1, 1996.

After the publication of the final regulation, I received numerous comments opposing its implementation. In

addition, I was made aware of the fact that the actuarial firm of Milliman and Robertson had performed an additional study which was not available at the time the original regulation was promulgated. This study suggested that an attachment point lower than $20,000 may be appropriate.

In light of these developments, I determined that a public hearing was appropriate. This hearing was held on November 13, 1995. Numerous witnesses testified regarding various preferred attachment points and the impact of the regulation on Maryland businesses.

I have carefully reviewed the testimony from the public hearing, written submissions received both before and after the hearing, and actuarial studies and materials relied on in the adoption of COMAR 09.31.02. Based on this review, I have determined to modify the regulation. As set forth below, I have concluded that a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims are appropriate. While higher levels can easily be justified, the new levels will have less of an impact on the business community in Maryland and at the same time carry out what I perceive to be important public policies of the State. Accordingly, I will immediately promulgate new regulations to reflect these modifications.

II. Background

Stop loss insurance is insurance purchased from a licensed carrier by a self-insured health plan. Stop loss coverage is intended to insure only against catastrophic or unexpected losses of the policyholder/employer who retains a majority of the risk of loss on himself. The plan, not its participants, is the beneficiary of the stop loss policy. A

stop loss policy contains an attachment point above which the insurer reimburses the plan for claims paid. Payment of claims below the attachment point is the responsibility of the plan and is not reimbursable. The attachment point is usually described in two ways: (1) a maximum amount per person per benefit year, generally with a lifetime cap; and (2) an aggregate amount, which is generally 100% or more of expected claims for the year. The specific attachment point protects the plan against catastrophic loss resulting from the severe illness or injury of one or more individuals during the benefit year. The aggregate attachment point protects against catastrophic loss to the plan if many plan participants become ill or injured resulting in higher than expected total claims for the self-insured group in a single year.

The Maryland Insurance Commissioner has regulated stop loss insurance and the appropriate attachment point levels for over twenty years. Policy forms for all insurance products sold in Maryland are required to be submitted for approval under the Insurance Code. Since the mid 1980's the Maryland Insurance Administration and its predecessor, the Insurance Division of the Department of Licensing and Regulation, employed a minimum specific attachment point of $25,000 as well as a variable aggregate attachment point. A policy which did not contain these attachment points would not be approved as a policy of stop loss insurance. Any policy with attachment points lower than these levels was considered to be a policy of health insurance and, as such, was required to offer the mandated benefits passed by the General Assembly. This long-standing interpretation and policy was never promulgated in regulations, but nonetheless was consistently applied over the years.

During 1993 and 1994, the Insurance Administration received a number of complaints regarding the availability in the marketplace of stop loss policies with specific attachment points as low as $500 or $1,000. It appears that the emergence of extremely 'ow attachment points coincided with the implementation of House Bill 1359, the Maryland Health Insurance Reform Act of 1993. At very low attachment points, however, a "stop loss" policy is merely a substitution for health insurance. It does not insure only against catastrophic loss. The self-funded health benefit plan is not regulated by the Insurance Commissioner and is not required to provide any of the state-mandated benefits. The goal is obvious: As policies became available with attachment points lower than many deductibles, it became an increasingly attractive option to "self-insure" a health plan, but to continue to shift the majority of the risk to the insurance carrier by purchasing "stop loss" coverage.

The effect of having a low attachment point is that the insurance carrier issuing the "stop loss" coverage is, in reality, providing direct health insurance. The attachment point is merely a deductible. The licensed carrier therefore avoids all mandates and all consumer protections. Insurers selling approved products spend a great deal of time and money to develop new products to comply with term and rate filing requirements and to remain competitive in light of the long list of Maryland mandated benefits. Their efforts are being undercut by companies selling unapproved stop loss policies with attachment points in violation of Maryland rules. This results in unfair competition in the insurance market.

The Insurance Administration is mandated to protect the citizens of this State from the actions of unlicensed insurance carriers or the purchase of unapproved insurance products. The General Assembly has provided that Maryland citizens are entitled to certain mandated health benefits. When insurers undertake the subterfuge of categorizing an employer as self-insured, and thus exempt from the state's laws, yet provide an unapproved insurance product which acts as a replacement for direct insurance, consumers are denied the protections and benefits intended by the Maryland General Assembly.

III. The Regulation

In order to protect consumers, reduce unfair competition in the insurance market, and implement the public policies of the State, as expressed in H.B. 1359 and other provisions of the Insurance Code, I determined to formalize the MIA policy regarding stop loss insurance in regulation form. Determining the "correct" attachment points is not an exact science. In making my initial decision, I examined the actions of other states, the recommendation of the NAIC, the views of MIA staff, and the commentary of employers, insurers, and associations interested in the issue.

Recognizing that the establishment of specific and aggregate attachment points is an imperfect science, my staff undertook several months of research and review to determine whether the $25,000 and 125% levels set by guideline were most appropriate for Maryland. My staff conducted a survey of how stop loss policies were regulated in other states. The results of this survey indicated that, while many states regulate this coverage, only New Jersey

and New York enforced a specific attachment point at the same level as Maryland's. Although Maryland's highly urban population centers and high overall health care costs may justify its placement at the high end of the national average, nevertheless the MIA considered lowering its required specific attachment point.

In addition, the MIA closely followed the work of the National Association of Insurance Commissioners (NAIC). The NAIC drafted a Stop Loss Model Act in 1994 which was adopted by the NAIC Executive Committee in September 1995. Prior to the drafting stage, the NAIC commissioned an actuarial study by the firm Coopers & Lybrand. The ERISA Working Group of the NAIC initially developed a standard that when an employer passes on more than 50% of the risk of providing his employees' health care coverage to a stop loss carrier it has become a subterfuge for a health insurance policy. This standard was based on the premise that the lower the specific and aggregate attachment point is, the more risk is transferred from the plan to the stop loss carrier. A plan which transfers a large portion of its risk is not truly self-insured. The study itself undertook to analyze the transfer of risk from a self-insured benefit plan to a stop loss carrier. Based on the standard deviation method, the study calculated the percentage of self-insurance risk retained by the employer given several sample benefit packages. From the data produced in the study, the ERISA Working Group of the NAIC recommended a specific attachment point of $20,000 and an aggregate attachment point of 120% of expected claims.

I have reviewed the Coopers & Lybrand study, and believe that it is a professionally done and well reasoned report. I found it to be a reasonable and rational basis for selecting a $20,000 specific attachment point and think that

the NAIC was justified in recommending that point from an actuarial standpoint. Nothing I have heard or read since detracts at all from these conclusions.

Based on the regulatory guidance of the NAIC, the actuarial data on risk transfer, regulatory efforts of other states, the public, and my staff, I determined to require a specific attachment point of $20,000 rather than $25,000 and to retain an aggregate attachment point of 125% of expected paid claims.[1] These attachment points provide a reasonable basis for discriminating between health insurance and true stop loss insurance.

The regulation containing these attachment points was published in the Maryland Register in Volume 22, Issue 12 on June 9, 1995. The stated application was to all policies or contracts covering Maryland residents issued or renewed on or after January 1, 1996. Since the Administration had already received a great deal of input from a variety of sources prior to the publication of the regulation, it was determined that a public hearing was not necessary. However, comments were solicited until July 11, 1995. All comments received were considered. The regulation was published as a final regulation on August 24, 1995 and was effective 30 days later on September 24, 1995.[2]

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[1] Very few concerns were raised regarding the setting of the aggregate attachment point at 125% of expected claims.

[2] On May 15, 1995 a suit was filed in the United States District Court for the District of Maryland against myself as Commissioner and the Insurance Administration by five plaintiffs including an insurer, a TPA, and 3 employers. The suit (continued...)

IV. The Public Hearing

Subsequent to the final adoption of the Maryland stop loss regulation, public interest in the regulation increased dramatically. This coincided with the vote by the NAIC Executive Committee to finally approve the Stop Loss Model Act in September 1995. In Maryland, opponents of the regulation voiced concern in three areas. First, a small minority argued that any attempt to regulate stop loss insurance is preempted by the Employee Retirement Income Security Act, commonly known as ERISA. 29 U.S.C. §1001 et seq. Second, a large majority argued that a $20,000 specific attachment point is too high. Third, some opponents argued that the aggregate attachment point of 125% of expected paid claims is too high, particularly for large groups. There were supporters as well, who agreed that the regulation is necessary and that the selected attachment points were appropriate and fair. Due to the number of persons who wished to be heard, I decided to hold a public hearing to determine whether to amend the attachment points in the stop loss regulation.

The public hearing was held on November 13, 1995. A number of exhibits were introduced including Maryland's stop loss regulation, the Stop Loss Model Act of the NAIC, the Coopers & Lybrand actuarial study for the NAIC,

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(...continued)
challenges the MIA's authority to establish any attachment points based on ERISA preemption grounds. See American Medical Security, Inc., et al v. Insurance Commissioner & Administration, Civil No H 95-1463. No decision has been issued in this case.

minutes of the NAIC committees which considered the Model Act, and approximately 50 letters received by Associate Commissioner Reichel during the public comment period in June and July 1995. Eighteen witnesses testified. These witnesses represented a multitude of different opinions and backgrounds. Among the witnesses were 4 employers, 4 third party administrators, 6 insurers and several associations such as the Health Insurance Association of America. In addition to the oral testimony, I received a number of written documents on the 13th which were entered into the record. Among these documents were letters by various groups and a report by Blue Cross/Blue Shield of Maryland. At the close of oral testimony, I indicated that additional written submissions would be welcome until Friday, November 24, 1995. Additional submissions were received during this time.

The vast majority of all witnesses and commentators have expressed the view that some attachment point is appropriate. Nearly everyone agrees that at "low" attachment points, the policy in reality becomes a health insurance policy and not merely a catastrophic loss policy.[3] The only real disagreement concerns the meaning of "low". On this point, most witnesses testified that an attachment point of $10,000 or above was appropriate and would not be

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[3] Even Roger Bayne from American Medical Security, a plaintiff in the pending litigation regarding the stop loss regulation, testified that a specific attachment point of $500 is "abusive", that $2000 is "absurd", that some regulation is necessary, and that a specific attachment point in the $5000-10,000 range is reasonable.

overly burdensome to small and medium size employers.[4]

Since the hearing I have reviewed all the evidence available to me. I have again reviewed the actuarial study of Coopers & Lybrand. I have reviewed the Milliman and Robertson study, the transcript of oral testimony, all written submissions from both before and after the hearing, and the recommendations of my staff. In considering whether to amend the regulation as currently adopted, I have used my best judgment and expertise to protect the interests of the citizens of Maryland and principles of fairness and equity in the market. As always, I have been guided by the Insurance Code and the laws of Maryland in determining this issue. I have concluded that the regulation should be amended to require a specific attachment point of $10,000 and an aggregate attachment point of 115% of expected claims.

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[4] For example, Elizabeth Buck on behalf of the Prince George's Chamber of Commerce and Buck Distributing (having 100 employees) testified that $10,000 would be fair. William Gordon of Belfort Instrument Company (having 35 employees) has had specific attachment points of $10,000 and 12,500. Anita Wagner of Mason, Ketterman & Morgan (having 60 employees) has had specific attachment points of $7,500, $10,000, and $12,500. Dennis Mather of Mather & Morgan testified that groups using a specific attachment point below $10,000 are clearly not self-insured. Robert Erskine of Employee Security Inc. (a TPA), Dennis Fuller of Chesapeake Administrators (a TPA), and Robert Sacks of Denta-Check (an insurer) support $10,000.

V. Discussion

A number of issues have been raised regarding the stop loss regulation, including ERISA preemption, the size of the specific attachment point, the amount of the aggregate attachment point, whether the regulation applies to claims incurred or paid during the policy period, whether a stop loss policy can offer either an aggregate or a specific attachment point, and whether claims can be paid directly by the carrier. Each of these issues are discussed below.

(1) ERISA PREEMPTION

ERISA was intended to ease the administration of employee benefit plans for multi-state employers and to prevent the mismanagement of plan funds by requiring compliance with federal standards for reporting, disclosure, and fiduciary responsibility. To this end, ERISA preempts state laws which "relate to" an employee welfare benefit plan and which are not "saved" from preemption under the savings clause as laws which regulate the business of insurance. ERISA specifically requires that an employee welfare benefit plan may not be deemed to be an insurance company for purposes of bringing it within the scope of state regulation. While in many ways ERISA preemption is broad, it is not so broad as to prevent Maryland from regulating health insurance sales.

The stop loss regulation under review does not "relate to" an ERISA plan as required by 29 U.S.C. §1144(a). Preemption does not occur if the state law has only a "tenuous, remote, or peripheral connection with covered plans". Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983). Thus, state laws of general application which make no

reference to ERISA plans are not preempted. State laws have been preempted where they require an ERISA plan to provide mandated benefits, Shaw v. Delta Airlines, 463 U.S. at 95-100; prohibit plan provisions, Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523-26, (1981); or force a certain benefit structure, Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10-11 (1987). Maryland's stop loss regulation does none of these things.

State laws that have a "connection" to ERISA plans require more than a mere burden or indirect cost on the administration of the plan to trigger preemption. The Supreme Court held in N.Y. State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 115 S.Ct. 1671 (1995) that New York's hospital surcharge system did not result in "such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers". Id. at 22. Indeed, "if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress." Rebaldo v. Cuomo, 749 F.2d 133, 138-9 (2nd Cir. 1984), cert. denied, 472 U.S. 1008 (1985). The mere fact that a state law has some economic effect on an ERISA plan does not require that the law be invalidated.[5]

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[5] While some opponents of Maryland's stop loss regulation have argued that compliance with the $20,000 specific attachment point would economically affect their employee benefit plans, this potential "indirect economic influence" is not sufficient to trigger preemption. A state law may have an "indirect economic influence" on an ERISA plan without relating

(continued...)

Even if a state law is found to "relate to" an employee benefit plan, this, by itself, is not fatal. ERISA provides an exception for state laws which regulate the business of insurance, referred to as the "savings clause". 29 U.S.C. § 1144(b)(2)(A). Maryland's regulation, which is directed solely at authorized insurance carriers in the state, regulates the insurance contract itself. It does not purport to, nor could it, regulate employer plans. The regulation merely delineates the difference between two types of insurance policies: stop loss policies and health insurance policies. The regulation in no way attempts to influence or regulate the underlying ERISA plan. The Insurance Administration is neither requiring a self-funded plan to purchase a fully insured health plan nor even encouraging them to do so. The stop loss regulation does not regulate the type of benefits that must be provided by ERISA plans nor does it create any reporting, disclosure, funding, or vesting requirements for the ERISA plan. The regulation merely defines the point below which the sale of "stop loss" insurance is, in fact, health insurance with a deductible rather than catastrophic loss coverage.

In summary, I am persuaded that the stop loss

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to the plan in a way that constitutes regulation of the plan itself. The stop loss regulation does not bind plan administrators to any particular choice of benefit package or financing option. Indeed, it is entirely up to the self-funded plan to determine, as an individual business decision, what benefit package to offer, whether to purchase stop loss coverage, and, ultimately, whether to self-insure at all.

regulation, as currently drafted, is not preempted by ERISA. The regulation does not "relate to" an ERISA plan in that it has such an indirect impact on such a plan as to not constitute a connection with the plan. Moreover, even if the regulation is found to relate to an ERISA plan, it is saved from preemption because it regulates the business of insurance, a subject solely within the jurisdiction of the states to regulate.

(2) SPECIFIC ATTACHMENT POINT

As discussed above, I have carefully reviewed the actuarial study conducted by Jim Robinson of Coopers & Lybrand on behalf of the NAIC. I believe this report contains an excellent analysis of risk shifting where stop loss insurance is purchased. I continue to believe that this report would readily support a $20,000 specific attachment point. Nonetheless, I have considered other evidence, including the attachment points which are used in other states[6] and the testimony at the public hearing. One of the interested groups commissioned a study by the firm Milliman and Robertson. This study purported to provide an alternative analysis for selecting the appropriate attachment points. It appears to indicate that, for groups of 50 lives or more, the expected level of claims retained by an employer would equal those ceded to a stop loss carrier at a specific attachment point of $10,000. Thus, the actuarial

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[6] Most of the states which regulate stop loss insurance require a $10,000 specific attachment point, including Missouri, Minnesota, Colorado, Kansas, Tennessee, Oregon, and Maine. Some states require a higher level; New York and New Jersey, for example, require a $25,000 specific attachment point.

evidence clearly supports an attachment point of at least $10,000. In my view, any amount below this minimum would not be true stop loss coverage and it may well be that a higher figure is appropriate.[7]

I also recognize that selecting an attachment point is not an exact science and requires the exercise of informed judgment. In exercising my regulatory judgment, I believe that a $10,000 specific attachment point is a reasonable compromise which will not be unduly burdensome to employer groups, but at the same time will carry out the basic public policies of the State as expressed by the General Assembly in the Insurance Code. As with any regulation, this attachment point will be subject to modification at some future date in the event that it is shown to have been too low in actual practice.

(3) AGGREGATE ATTACHMENT POINT

In the current regulation, the aggregate attachment point is 125% of expected claims. The NAIC Model Act set the figures at 120% of expected claims for small employers and

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[7] Arthur Wilmes, a consulting actuary with the firm Milliman and Robertson and author of the study reviewing the 1994 Coopers & Lybrand report testified at the public hearing. He was questioned by the MIA's Chief Actuary and myself on the soundness and relevance of his study. I am convinced that both studies are actuarially sound. The Coopers & Lybrand study represents a stricter standard of risk transfer, while the Milliman and Robertson study represents a less strict measure for risk transfer. Both studies are useful to a regulator in choosing appropriate attachment points.

110% for large employers. Several individuals testified at the hearing that 125% or even 120% were too high, especially for large groups.

My actuarial expertise convinces me that for large groups, a figure in excess of 115% of expected claims is unwarranted. Several witnesses suggested that a sliding scale of attachment points based on the size of the group would be preferable. I have determined, however, that such a method would be impractical from a regulatory standpoint and believe it is incumbent on me to select the most reasonable and effective attachment point for stop loss policies generally. Accordingly, I have concluded that 115% is an appropriate figure for an aggregate attachment point and will be applicable to groups of any size.

(4)- "CLAIMS INCURRED" VERSUS "CLAIMS PAID"

The regulation states that the aggregate attachment point minimum is 125% of expected paid claims. Richard Gorenflo of MAMSI raised an issue regarding this language. He noted that claims which are incurred but not paid during a policy period result in a "tail" of liability which does not become apparent until after the policy period ends. The regulation is not intended to create a situation where tail liability may impact a policyholder. Accordingly, we have amended the regulation to define "expected claims" as those claims projected to be incurred by a plan in a given benefit year. The aggregate attachment point will therefore be calculated by applying 115% to those expected incurred claims.

(5) "AND" VERSUS "OR"

The regulation as drafted reads in .03(B)(3) and (4), "The specific attachment point ... is at least $20,000 per employee, dependent, member, or participant per year; and (4) The aggregate attachment point ... is, at a minimum, 125 percent of expected paid claims...". There appears to be some confusion on the part of the public as to whether this language requires a stop loss policy to provide both a specific and an aggregate attachment point in every policy or simply that a policy containing either must comply with the required minimum attachment point applicable to it. I have therefore amended the language of the regulation to read "if the policy contains a specific attachment point, the specific attachment point shall be at least $10,000..." and "if the policy contains an aggregate attachment point, the aggregate attachment point shall be 115 percent of expected claims..." to clarify that a stop loss policy need not contain both a specific and an aggregate attachment point, but either attachment point it does contain must meet the minimum requirement. This result is in accordance with the NAIC Model Act, industry practice, and sound actuarial assumptions.

(6) STOP LOSS CARRIER REIMBURSING THE EMPLOYER RATHER THAN THE PROVIDER

The regulation currently requires that the stop loss carrier make payments only to the plan, its sponsor or the administrator of the plan and not to either the employees or providers directly. See .03(B)(2) Blue Cross and Blue Shield has asserted that this requirement would create administrative and contractual difficulties in that it frequently reimburses providers directly under the terms of

its administrative service agreements. The regulation is not intended to prohibit an insurance carrier from functioning both as an administrator and as a stop loss insurer, provided respective contractual liabilities are clear. I have determined to amend this language to clarify that a carrier is liable for payment only to the plan itself and not to plan beneficiaries or providers, regardless of whether a carrier, in its capacity as administrator of the plan, actually makes the payments.

The purpose of the regulation is to define what is true stop loss coverage. Such coverage reimburses a plan for claims above the attachment point. Thus carriers will be required to exercise care to ensure that their administrative functions are consistent with their contractual liability. This result is required by the regulation's purpose of clearly differentiating these two types of policies.

CONCLUSION

For all the above reasons, I have determined that the stop loss regulation COMAR 09.31.02 shall be amended to reflect a minimum specific attachment point of $10,000 and a minimum aggregate attachment point of 115% of expected incurred claims, either of which will be sufficient to approve a policy of stop loss insurance. I will propose that this amended regulation be promulgated on an emergency basis.

So ORDERED this 8th of December, 1995.

Dwight K. Bartlett, III
Maryland Insurance Commissioner

CODE OF MARYLAND REGULATIONS

09.31.02

Subtitle 31 MARYLAND INSURANCE ADMINISTRATION

Chapter 02 Health Insurance--Stop-Loss Coverage

Authority: Article 48A §§ 26, 66, and 213, Annotated Code of Maryland

.01 Scope.

These regulations apply to all policies or contracts covering Maryland residents which are issued or renewed on or after January 1, 1996.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Aggregate attachment point" means the dollar amount per plan beyond which the carrier issuing the stop-loss health insurance coverage assumes some or all of the plan's liability for payment of covered services or benefits.

(2) "Carrier" means:

(a) An insurer that holds a certificate of authority in the State and provides or is authorized to

provide health insurance in the State; or

(b) A nonprofit health service plan that is authorized to operate in the State and provides or is authorized to provide health insurance in the State.

(3) "Expected claims" means the amount of claims that, in the absence of a stop-loss policy or other insurance, are projected to be incurred by a plan.

(4) "Plan" means employer-sponsored group health insurance coverage.

(5) "Specific attachment point" means the dollar amount per employee, dependent, member, subscriber, or participant, per year beyond which the carrier issuing the stop-loss health insurance coverage assumes some or all of the plan's liability for payment of covered services or benefits.

(6) "Stop-loss health insurance coverage" means a policy, contract endorsement, attachments, amendments, or other modifications to that contract, issued to an employer, or a trustee or association acting on behalf of that employer, to insure against losses of an employer's health plan.

.03 Coverage.

A. A policy or contract issued to an employer which insures against losses or claims resulting from the bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, or childbirth, or against expenses incurred in prevention of sickness, or dental care,

of the employees of that employer is considered to be a policy or contract of health insurance.

B. A policy or contract issued to an employer may be considered to be a policy or contract of stop-loss health insurance coverage only if:

(1) The stop-loss coverage is issued to and insures the sponsor or administrator of the plan or the plan itself and is not issued to employees, dependents, members, or participants;

(2) The carrier is liable for payments only to the sponsor or administrator of the plan or the plan itself and not to the employees, dependents, members, subscribers, participants, or providers;

(3) If the policy contains a specific attachment point, the specific attachment point shall be at least $10,000 per employee, dependent, member, subscriber or participant per year; and

(4) If the policy contains an aggregate attachment point, the aggregate attachment point shall be, at a minimum, 115 percent of expected claims for all employees, dependents, members, subscribers or participants.

.04 Taxes.

Premiums attributable to stop-loss health insurance coverage shall be allocated and taxes computed in accordance with Article 48A, Subtitle 47, Annotated Code of Maryland.

.05 Required Provisions.

An insurer issuing a stop-loss health insurance policy shall offer the applicant for the policy the option to purchase a policy that provides that if a claim begins while the stop-loss health insurance policy is in effect, the carrier shall continue to pay benefits for the continuance of the claim after the stop-loss health insurance coverage terminates, until the earlier of:

A. The date the claim terminates; or

B. 90 days from the termination of the stop-loss health insurance policy.

29 U.S.C.A. § 1144

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.